

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6575

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06567

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institutions: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>P. J.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN <i>30 minutes</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frank Harris Allen</i>		4. DATE OF DEATH <i>6</i> Month <i>1</i> Day <i>1953</i> Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 5, 1895</i>
9. AGE (In years last birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Patron</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Real estate</i>	
11. BIRTH PLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Harris Allen</i>		14. MOTHER'S MAIDEN NAME <i>Sallie Creas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>World 1</i>	
17. INFORMANT <i>Edward L. Allen</i>		Address <i>Prince Frederick</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Was eating supper alone he called a friend</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Choked to death in a bar</i>	
20c. TIME OF INJURY Month, Day, Year <i>6/1 1953</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Boston</i> (County) <i>Calvert</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) _____		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6/11/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/5/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Suitland Md</i> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville Md.</i>	
24a. REC'D BY REGISTRAR <i>JUN 3 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles L. Keane</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6576

CERTIFICATE OF DEATH

06568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabaret County Hosp.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Holland Point</u>			
				f. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>HERMAN BAWEN</u> First <u>ROFUS</u> Middle <u>B</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 6, 1873</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min.		IF UNDER 24 HRS. Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>			
11. BIRTHPLACE (State or foreign country) <u>Cabaret Co., Ind.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Benjamin H. Bawen</u>				14. MOTHER'S MAIDEN NAME <u>Susan Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Edward Bawen - Bawen, Ind.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Chronic obstructive pulmonary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>59</u> , to <u>3 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3 May</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <u>G. J. Weems</u> M.D.				DATE SIGNED <u>6/4/59</u>			
PHYSICIAN'S NAME (Type) <u>G. J. WEEMS</u>				<u>HUNTINGTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bawen - Cabaret Co - Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Harkness & Son - Mutual, Ind.</u>				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE <u>JUN 8 '59</u>				<u>Ashbury S. Harkness</u>			

8330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6577 Item 9 Film 6244 b-22-59 et
STATE OF MARYLAND
CERTIFICATE OF DEATH

06569

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Spencer</u> Middle <u>Freeland</u> Last <u>Freeland</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Freeland</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Morsell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emma Freeland</u>		Address <u>Prince Frederick</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage</u> (c) <u>Hypertensive c.v.d.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/3</u> , 19 <u>59</u> , to <u>6/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/10</u> , 19 <u>59</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Roberto de Villarreal</u> M.D.		ADDRESS (Street, city or town, state) <u>S. Thomas</u> DATE SIGNED <u>6/10/59</u>	
PHYSICIAN'S NAME (Type) <u>Roberto de Villarreal, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 13, 59</u>		22b. DATE THEREOF <u>Youngs</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown, Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u> ADDRESS <u>Prince Fred.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kins</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06570

Reg. Dist. No.

6578

Item 9 Film 6244 6-30-59 et

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Beach</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Beach</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Bernard Joseph Garrity</u> First Middle Last				4. DATE OF DEATH <u>6</u> Month <u>20</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship yard</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
13. FATHER'S NAME <u>Bernard J. Garrity</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Pearson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>243-16-6990</u>		17. INFORMANT <u>Mrs. B. J. Garrity, W. Beach, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>782.4 Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> DUE TO (c) <u>Due to</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was taken with pain in chest & abdomen</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>6/20/59</u> Hour <u>1:30</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>W. Beach</u> (County) <u>Calvert</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. W. WARD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 23, 1959</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Harmony</u>		22d. LOCATION (City, town, or county) <u>W. Beach</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u> ADDRESS <u>W. Beach, MD</u>				24a. REC'D BY REGISTRAR <u>JUN 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kuma</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06571

6579

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 16 Film 244 7-14-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> 02x-2			
f. STREET ADDRESS <u>730 Ways Rd</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Richard</u> First <u>Haase</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/4/89</u>	
9. AGE (In years and birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hair Stylists</u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Julius Haase</u>				14. MOTHER'S MAIDEN NAME <u>Miss Albertina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>051-14-0149</u>			
17. INFORMANT <u>Hospital Chat</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was sent to CCH from A&C and died with out</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>leg run by a local M&R</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.W. Ward</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.W. Ward</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>June 22, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Hana</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF CREMATION PLACE		19. SIGNATURE OF INTERMENT PLACE		20. SIGNATURE OF REINTERMENT PLACE	
21. SIGNATURE OF REINTERMENT PLACE		22. SIGNATURE OF REINTERMENT PLACE		23. SIGNATURE OF REINTERMENT PLACE		24. SIGNATURE OF REINTERMENT PLACE		25. SIGNATURE OF REINTERMENT PLACE	
26. SIGNATURE OF REINTERMENT PLACE		27. SIGNATURE OF REINTERMENT PLACE		28. SIGNATURE OF REINTERMENT PLACE		29. SIGNATURE OF REINTERMENT PLACE		30. SIGNATURE OF REINTERMENT PLACE	
31. SIGNATURE OF REINTERMENT PLACE		32. SIGNATURE OF REINTERMENT PLACE		33. SIGNATURE OF REINTERMENT PLACE		34. SIGNATURE OF REINTERMENT PLACE		35. SIGNATURE OF REINTERMENT PLACE	
36. SIGNATURE OF REINTERMENT PLACE		37. SIGNATURE OF REINTERMENT PLACE		38. SIGNATURE OF REINTERMENT PLACE		39. SIGNATURE OF REINTERMENT PLACE		40. SIGNATURE OF REINTERMENT PLACE	
41. SIGNATURE OF REINTERMENT PLACE		42. SIGNATURE OF REINTERMENT PLACE		43. SIGNATURE OF REINTERMENT PLACE		44. SIGNATURE OF REINTERMENT PLACE		45. SIGNATURE OF REINTERMENT PLACE	
46. SIGNATURE OF REINTERMENT PLACE		47. SIGNATURE OF REINTERMENT PLACE		48. SIGNATURE OF REINTERMENT PLACE		49. SIGNATURE OF REINTERMENT PLACE		50. SIGNATURE OF REINTERMENT PLACE	
51. SIGNATURE OF REINTERMENT PLACE		52. SIGNATURE OF REINTERMENT PLACE		53. SIGNATURE OF REINTERMENT PLACE		54. SIGNATURE OF REINTERMENT PLACE		55. SIGNATURE OF REINTERMENT PLACE	
56. SIGNATURE OF REINTERMENT PLACE		57. SIGNATURE OF REINTERMENT PLACE		58. SIGNATURE OF REINTERMENT PLACE		59. SIGNATURE OF REINTERMENT PLACE		60. SIGNATURE OF REINTERMENT PLACE	
61. SIGNATURE OF REINTERMENT PLACE		62. SIGNATURE OF REINTERMENT PLACE		63. SIGNATURE OF REINTERMENT PLACE		64. SIGNATURE OF REINTERMENT PLACE		65. SIGNATURE OF REINTERMENT PLACE	
66. SIGNATURE OF REINTERMENT PLACE		67. SIGNATURE OF REINTERMENT PLACE		68. SIGNATURE OF REINTERMENT PLACE		69. SIGNATURE OF REINTERMENT PLACE		70. SIGNATURE OF REINTERMENT PLACE	
71. SIGNATURE OF REINTERMENT PLACE		72. SIGNATURE OF REINTERMENT PLACE		73. SIGNATURE OF REINTERMENT PLACE		74. SIGNATURE OF REINTERMENT PLACE		75. SIGNATURE OF REINTERMENT PLACE	
76. SIGNATURE OF REINTERMENT PLACE		77. SIGNATURE OF REINTERMENT PLACE		78. SIGNATURE OF REINTERMENT PLACE		79. SIGNATURE OF REINTERMENT PLACE		80. SIGNATURE OF REINTERMENT PLACE	
81. SIGNATURE OF REINTERMENT PLACE		82. SIGNATURE OF REINTERMENT PLACE		83. SIGNATURE OF REINTERMENT PLACE		84. SIGNATURE OF REINTERMENT PLACE		85. SIGNATURE OF REINTERMENT PLACE	
86. SIGNATURE OF REINTERMENT PLACE		87. SIGNATURE OF REINTERMENT PLACE		88. SIGNATURE OF REINTERMENT PLACE		89. SIGNATURE OF REINTERMENT PLACE		90. SIGNATURE OF REINTERMENT PLACE	
91. SIGNATURE OF REINTERMENT PLACE		92. SIGNATURE OF REINTERMENT PLACE		93. SIGNATURE OF REINTERMENT PLACE		94. SIGNATURE OF REINTERMENT PLACE		95. SIGNATURE OF REINTERMENT PLACE	
96. SIGNATURE OF REINTERMENT PLACE		97. SIGNATURE OF REINTERMENT PLACE		98. SIGNATURE OF REINTERMENT PLACE		99. SIGNATURE OF REINTERMENT PLACE		100. SIGNATURE OF REINTERMENT PLACE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06572**

6580

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drumkirk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admision) a. STATE Md b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drumkirk d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Larry James Jenkins First Middle Last 4. DATE OF DEATH 6 28 1959 Month Day Year		5. SEX M 6. COLOR OR RACE K 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Oct 23, 1958 9. AGE (In years last birthday) 8 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dennis Jenkins		14. MOTHER'S MAIDEN NAME Mary Savoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Dennis Jenkins, Drumkirk, Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation when he got hung in his crib DUE TO (b) 9240 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found with head caught in between planks 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Head & neck caught in bed and got caught	
20c. TIME OF INJURY Month, Day, Year 8 6 28 1959 Hour P. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Drumkirk (County) Calvert (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H W Ward EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-37		22b. DATE THEREOF 6-37	
22c. NAME OF CEMETERY OR CREMATORY moose		22d. LOCATION (City, town, or county) A.A. County (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell ADDRESS Pr. Frederick		24a. REC'D BY REGISTRAR JUL 1 1959 DATE 24b. REGISTRAR'S SIGNATURE Calvert E. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2063203XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caldwell</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>P.S.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		1641-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>403 Talbot St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Tommy</u> Middle <u>Cecil</u> Last <u>Luber</u>				4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/29/02</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electric Shop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Lusby Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Kuber</u>				14. MOTHER'S MAIDEN NAME <u>Cecilia Pauline Piege</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>720-10-5474</u>		17. INFORMANT Address <u>403 Talbot St</u> <u>Mrs Louis C. Luber Lusby Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>782.4</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Blow to stomach</u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Drowned dead as he got out of boat</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>4:30</u> P. M. <u>6/13</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Lusby Md</u>		20f. (City or town) (County) (State) <u>Lusby Caldwell Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. W. WARD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lusby Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lusby Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				ADDRESS <u>Lusby Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>H. Beach</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md DC</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>3942 Ames St NE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Chapman</u> Middle <u>Mann</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22/1892</u> 9. AGE (in years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Bank Wash DC</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Mann</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Carol</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both) <u>No</u>		16. SOCIAL SECURITY NO. <u>512-0-2548</u>	
17. INFORMANT <u>Francis A. Mann Jr</u> Address <u>512-0-2548 Rd 11</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>782.4</u> DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiac failure</u> (a), stating the underlying cause last. DUE TO (c) <u>Cardiac failure</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was found dead sitting in a chair on lawn</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>which he had been working</u>	
20c. TIME OF INJURY Month, Day, Year <u>430</u> Hour <u>6/20</u> p.m. <u>1259</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Ches Beach Calvert MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H W Ward</u>		DATE SIGNED <u>6/20/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/1/59</u>		22b. DATE THEREOF <u>6/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Handan</u> ADDRESS <u>3831 G Ave NW</u>		24a. REC'D BY REGISTRAR <u>JUN 23 '59</u> DATE <u>6/23/59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

6583

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>MD</u> <u>158-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Donald Michael Marsh</u>		4. DATE OF DEATH Month Day Year <u>6</u> <u>14</u> <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4 1948</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash DC</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ronald Marsh</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Moran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Donald Marsh</u>		Address <u>Bethesda MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>929.8</u> DUE TO (c) <u>Found floating face down</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found floating face down</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Had been in swimming 30 min</u>	
20c. TIME OF INJURY Month, Day, Year <u>3</u> <u>6/14</u> <u>1959</u> Hour p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ches. Bay</u>	20f. (City or town) (County) (State) <u>St. Leonard</u> <u>Calvert</u> <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		DATE SIGNED <u>6/14/59</u>	
EXAMINER'S NAME (Type) <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Evans</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>JUN 17 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6584

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u>		c. LENGTH OF STAY IN 1b		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>Md</u> <u>1526-2</u>		f. STREET ADDRESS <u>322 Cedar Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clark</u> Middle <u>Richard</u> Last <u>Neal</u>				4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10, 1951</u>		9. AGE (In years last birthday) <u>7</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lawrence Richard Neal</u>				14. MOTHER'S MARDEN NAME <u>Phyllis Jane Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lawrence R. Neal</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found floating face down in C Bay</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was swimming</u>					
20c. TIME OF INJURY Month, Day, Year <u>3</u> <u>6/14</u> <u>1959</u> Hour <u>a</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, Portery, street, office bldg., etc.) <u>Ches. Bay</u>		20f. (City or town) (County) (State) <u>Long Beach</u> <u>Calvert</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. W. Ward</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 16 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6585

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick Md</i>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co</i>		f. STREET ADDRESS	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Preston</i> First <i>Plater</i> Middle <i>Plater</i> Last		4. DATE OF DEATH Month <i>6</i> Day <i>27</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 16,</i>
9. AGE (In years last birthday) <i>17</i> yrs.		10. IF UNDER 1 YEAR Months <i>17</i> Days <i>17</i> Hours <i>17</i> Min.	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wardell Plater</i>		14. MOTHER'S MAIDEN NAME <i>Beessie Reid</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>22-0367400</i>	
17. INFORMANT <i>Beessie Reid</i>		Address <i>Shuttersville Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broken neck and fractured skull</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Was dead before arrival</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Car accident Charles Cont Md</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>7:00</i> a.m. <i>627</i> p.m. <i>1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway 381</i>		20f. (City or town) <i>Brederick Charles Md</i>	
20g. (County) <i>Calvert</i>		20h. (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. (BURIAL) CREMATION, REMOVAL (Specify) <i>6-30-59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Pharm Point</i>		22d. LOCATION (City, town, or county) <i>Calvert Co, Md</i>	
22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. J. Sewell, Prince Fred</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>JUL 2 1959</i>		DATE	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

85222

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1582

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. OCCUPATION [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. DATE OF BIRTH [Faint text]	
7. PLACE OF DEATH [Faint text]		8. DATE OF DEATH [Faint text]	
9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF MEDICAL EXAMINER [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF CORONER [Faint text]		14. SIGNATURE OF JURY [Faint text]	
15. SIGNATURE OF JURY [Faint text]		16. SIGNATURE OF JURY [Faint text]	
17. SIGNATURE OF JURY [Faint text]		18. SIGNATURE OF JURY [Faint text]	
19. SIGNATURE OF JURY [Faint text]		20. SIGNATURE OF JURY [Faint text]	
21. SIGNATURE OF JURY [Faint text]		22. SIGNATURE OF JURY [Faint text]	
23. SIGNATURE OF JURY [Faint text]		24. SIGNATURE OF JURY [Faint text]	
25. SIGNATURE OF JURY [Faint text]		26. SIGNATURE OF JURY [Faint text]	
27. SIGNATURE OF JURY [Faint text]		28. SIGNATURE OF JURY [Faint text]	
29. SIGNATURE OF JURY [Faint text]		30. SIGNATURE OF JURY [Faint text]	
31. SIGNATURE OF JURY [Faint text]		32. SIGNATURE OF JURY [Faint text]	
33. SIGNATURE OF JURY [Faint text]		34. SIGNATURE OF JURY [Faint text]	
35. SIGNATURE OF JURY [Faint text]		36. SIGNATURE OF JURY [Faint text]	
37. SIGNATURE OF JURY [Faint text]		38. SIGNATURE OF JURY [Faint text]	
39. SIGNATURE OF JURY [Faint text]		40. SIGNATURE OF JURY [Faint text]	
41. SIGNATURE OF JURY [Faint text]		42. SIGNATURE OF JURY [Faint text]	
43. SIGNATURE OF JURY [Faint text]		44. SIGNATURE OF JURY [Faint text]	
45. SIGNATURE OF JURY [Faint text]		46. SIGNATURE OF JURY [Faint text]	
47. SIGNATURE OF JURY [Faint text]		48. SIGNATURE OF JURY [Faint text]	
49. SIGNATURE OF JURY [Faint text]		50. SIGNATURE OF JURY [Faint text]	
51. SIGNATURE OF JURY [Faint text]		52. SIGNATURE OF JURY [Faint text]	
53. SIGNATURE OF JURY [Faint text]		54. SIGNATURE OF JURY [Faint text]	
55. SIGNATURE OF JURY [Faint text]		56. SIGNATURE OF JURY [Faint text]	
57. SIGNATURE OF JURY [Faint text]		58. SIGNATURE OF JURY [Faint text]	
59. SIGNATURE OF JURY [Faint text]		60. SIGNATURE OF JURY [Faint text]	
61. SIGNATURE OF JURY [Faint text]		62. SIGNATURE OF JURY [Faint text]	
63. SIGNATURE OF JURY [Faint text]		64. SIGNATURE OF JURY [Faint text]	
65. SIGNATURE OF JURY [Faint text]		66. SIGNATURE OF JURY [Faint text]	
67. SIGNATURE OF JURY [Faint text]		68. SIGNATURE OF JURY [Faint text]	
69. SIGNATURE OF JURY [Faint text]		70. SIGNATURE OF JURY [Faint text]	
71. SIGNATURE OF JURY [Faint text]		72. SIGNATURE OF JURY [Faint text]	
73. SIGNATURE OF JURY [Faint text]		74. SIGNATURE OF JURY [Faint text]	
75. SIGNATURE OF JURY [Faint text]		76. SIGNATURE OF JURY [Faint text]	
77. SIGNATURE OF JURY [Faint text]		78. SIGNATURE OF JURY [Faint text]	
79. SIGNATURE OF JURY [Faint text]		80. SIGNATURE OF JURY [Faint text]	
81. SIGNATURE OF JURY [Faint text]		82. SIGNATURE OF JURY [Faint text]	
83. SIGNATURE OF JURY [Faint text]		84. SIGNATURE OF JURY [Faint text]	
85. SIGNATURE OF JURY [Faint text]		86. SIGNATURE OF JURY [Faint text]	
87. SIGNATURE OF JURY [Faint text]		88. SIGNATURE OF JURY [Faint text]	
89. SIGNATURE OF JURY [Faint text]		90. SIGNATURE OF JURY [Faint text]	
91. SIGNATURE OF JURY [Faint text]		92. SIGNATURE OF JURY [Faint text]	
93. SIGNATURE OF JURY [Faint text]		94. SIGNATURE OF JURY [Faint text]	
95. SIGNATURE OF JURY [Faint text]		96. SIGNATURE OF JURY [Faint text]	
97. SIGNATURE OF JURY [Faint text]		98. SIGNATURE OF JURY [Faint text]	
99. SIGNATURE OF JURY [Faint text]		100. SIGNATURE OF JURY [Faint text]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06578

6586

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Smith Ward</u>				4. DATE OF DEATH <u>6</u> Month <u>22</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25 1906</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Robert S Ward Jr</u>				14. MOTHER'S MAIDEN NAME <u>Elva Norfolk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-328444</u>		17. INFORMANT <u>John Ward Dorsey Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>782.4</u> DUE TO (c) <u>Found dead in bathroom</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bathroom</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>9</u> Hour <u>6132</u> <u>19</u> <u>59</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. City or town (County) (State) <u>Dorsey Calvert Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H W Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. W. WARD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 25, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithville</u>		22d. LOCATION (City, town, or county) (State) <u>Dunkirk Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home, Dorsey Md</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>JUN 26 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

6587

CERTIFICATE OF DEATH

06579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Wayne Wood</u> First Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/1933</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marine</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas B Wood</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-8244</u>	
17. INFORMANT <u>Joseph Albert Prince Frederick Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>59</u> , to <u>6/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/19</u> , 19 <u>59</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D. <u>O'Byrne Md</u>		DATE SIGNED <u>6/19/59</u>	
PHYSICIAN'S NAME (Type) <u>H. W. WARD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 21, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Friendship Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick's Funeral Home, Owings Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 24 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00230

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

8885

Date of Birth

Date of Death

Date of Burial

Date of Interment

Date of Cremation

Date of Disposition

Date of Return

Date of Reburial

Date of Reinterment

Date of Recremation

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition

Date of Redisposition